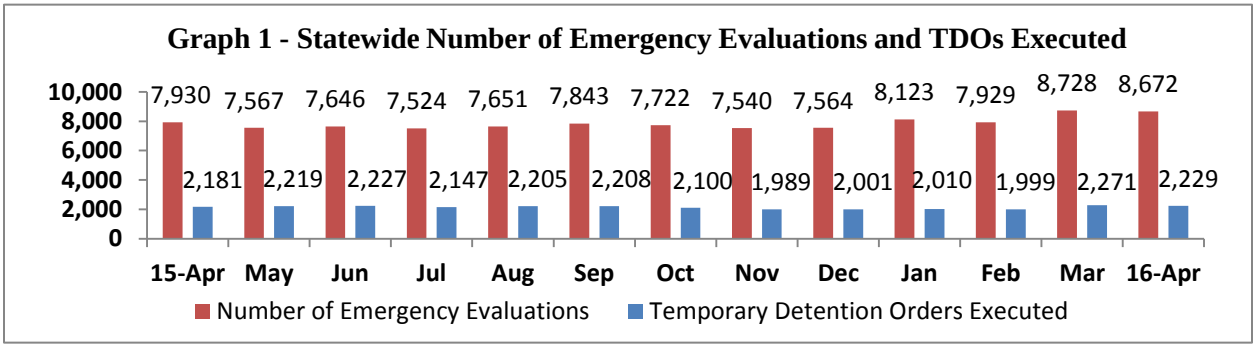
This document is the tenth monthly report of data collected from community services boards (CSBs) and partnership planning regions for fiscal year 2016 (FY 2016). There are 39 CSBs and one behavioral health authority in Virginia, referred to in this report as CSBs. The following sections contain the summaries and graphs of the monthly data reported to the Department of Behavioral Health and Developmental Services (DBHDS) through April 2016.

CSBs collect and report data on exceptional events associated with emergency custody orders (ECOs), temporary detention orders (TDOs), and involuntary admissions under the revised statutes effective July 1, 2014, and the factors contributing to these events. DBHDS requires this data to be submitted monthly by each CSB. DBHDS also requires case-specific reports from individual CSBs within 24 hours of any event involving an individual who has been determined to require temporary detention for whom the TDO is not executed for any reason, whether or not an ECO was issued or in effect. Previous reports are available on the Department of Behavioral Health and Developmental Services (DBHDS) website at http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data.

Graph 1. Statewide Emergency Evaluations and TDOs Executed

Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. The number of emergency evaluations reported statewide in April 2016 was 8,672, a 1% decrease from March 2016. A TDO is issued by a magistrate after considering the findings of the CSB evaluation and other relevant evidence and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1 of the Code of Virginia. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the order. In April, there were 2,229 executed TDOs, a decrease of 2% from March 2016. **About 74% of the emergency evaluations reported in April (6,443 of 8,672) did not result in a TDO.** For the current report month, there was an average of 289 emergency evaluations completed and about 74 TDOs issued and executed each day across the state. Compared to the March counts, these figures were about the same. Graph 1 reports the numbers of evaluations and executed TDOs for April 2016 and the preceding 12 months to show trends.



TDO Exception Reports

When certain high risk events occur during the evaluation and TDO process, CSBs report these incidents on a case-by-case basis as they occur. These involve individuals who are evaluated and need temporary detention, but do not receive that intervention. There were seven events in April. Each event triggers submission of an incident report to members of the DBHDS Quality Team within 24 hours of the event. The members receiving the initial reports are Daniel Herr, Assistant Commissioner of Behavioral Health, Stacy Gill, Director of Behavioral Health Services, and Mary Begor, Crisis Services Coordinator. The report is reviewed with particular attention on actions taken to resolve the event and what is done by the CSB to prevent such occurrences in the future. Additional information and follow up questions are asked of the CSB as needed. CSBs continue to update DBHDS until the situation is resolved and follow up is completed. On a monthly basis, the reported events are presented to the Behavioral Health Quality Review Committee which reviews follow-up actions, and identifies, monitors, and analyzes trends and oversees the implementation of continuous quality improvement measures.

As a result of the event reviews, DBHDS modified the report form to include a section if the person had a confirmed or suspected intellectual or development disorder (IDD) and whether REACH, the crisis response system for individuals with IDD and their families were contacted. Events related to the contacting of REACH were not included in this review of reports.

The details of each of the seven reported events are described below.

1. The individual was evaluated, and found to meet criteria for TDO, following a transfer from a medical unit to a behavioral health unit of a local hospital. When the certified preadmission screener petitioned the magistrate for a TDO, the magistrate declined to issue the TDO based on the testimony presented by the screener. The screener informed the hospital that the physician could petition the magistrate for the TDO; however, the hospital and physician declined. The hospital advised the individual's parents to supervise the individual upon release, but the parents declined to be involved.

DBHDS reviewed the event and had no recommendations at the time.

2. The individual was evaluated on the medical unit of a local hospital and was determined to meet criteria for a TDO. The evaluator began searching for an appropriate placement; however, the search extended into the next shift. The search was interrupted because a contacted facility questioned the medical stability of the individual. In the meantime, the individual expressed a desire to leave the hospital. Therefore, the CSB pursued an ECO. After medical concerns were treated, the CSB continued seeking a willing facility. The CSB was informed by the hospital the individual left the hospital sometime during the prior evening and the hospital acknowledged they did not contact the CSB. The hospital reports having a staff member follow the individual and reported the individual went home. The hospital did not notify police or APS for assistance at the time. The CSB sought a TDO and the individual was taken into custody by the local police at home.

   The preadmission screeners involved with this documented contacts with the medical facility as well as with their supervisors and agency management throughout the process. The CSB reviewed the event with the hospital administration during their monthly meeting and requested the hospital provide the CSB with timely notification of individuals asking to or leaving the hospital once a TDO has been recommended.

   DBHDS reviewed the events and the actions taken by the CSB to collaborate with the hospital and offered no additional recommendations.

3. The individual was evaluated and determined to meet TDO criteria. When the police arrived to execute the order they arrested the individual on an outstanding warrant instead of executing the TDO. The individual was transported and processed into the regional jail. The CSB evaluator contacted the regional jail staff to express concern for the individual's safety. The jail agreed to implement safety protocol for the individual and to notify the CSB if the individual is to be released. The jail also agreed to notify their on-call mental health worker of the situation. The CSB notified the General District Court and the Commonwealth Attorney of the concerns and the need to contact the CSB if the individual is to be released at arraignment. The CSB also notified the clerk of the court where the charges initiated and asked for the CSB to be contacted to complete another evaluation prior to the release of the individual. It was determined the individual would not be released in the foreseeable future.

   DBHDS reviewed the event with no recommended actions beyond what the CSB did to ensure the safety of the individual.

4. A TDO was obtained on an individual for a local behavioral health unit. The hospital notified the CSB after the arrival of the individual to the unit that the individual was being discharged from the behavioral health unit due to a fracture that required surgery. The individual was moved to a medical unit; therefore, the CSB cancelled the commitment hearing. On the morning of the originally scheduled hearing, the hospital contacted the CSB stating the individual had not been discharged and would require a commitment hearing on the medical floor. Since the CSB canceled the initial hearing based on the information provided, the independent evaluator did not complete an assessment. Without the evaluation, the special justice dismissed the hearing.

   The CSB asked the hospital to conduct an evaluation to determine whether the individual was still in need of inpatient psychiatric care and to notify the CSB. The CSB contacted the case manager on the medical unit to confirm the psychiatric consult had been requested and completed. The consult determined the individual was not in need of inpatient treatment at the time. The CSB met with the director of the behavioral health unit to discuss this event and to work together to prevent this from occurring in the future.

   DBHDS reviewed this event and the actions taken by the CSB and offered no additional recommendations.

5. The CSB was contacted to evaluate an individual who was in an emergency department and under an ECO. The clinician conducted the evaluation and left the area to write up the evaluation and to review the individual's medical status with the emergency department nurses. The clinician was informed by the nursing personnel the individual had been discharged. Both the deputy and the individual left the emergency department. The clinician did not intend to seek a TDO on the individual but was concerned the individual left without a plan for safety and treatment. The clinician contacted the individual's emergency contact and determined the individual was safe and was going to be with the individual through the night. The individual verbalized intent to return to a treatment program. The CSB spoke to the emergency department staff regarding the discharge of the individual prior to ES releasing the ECO. The ECO protocols were reviewed with the staff. The CSB contacted the sheriff's department regarding the deputy releasing the individual without consulting with the CSB. The CSB processed this event at the CIT meeting to remind law enforcement of the importance of maintaining custody of an individual under an ECO until the preadmission screening clinician releases the individual.

   DBHDS reviewed the event and the actions of the CSB in response to the event and offered no additional recommendations.

6. The individual made threats to a service provider prompting the CSB's emergency services to seek assistance with local police for a wellness check on the individual. Law enforcement located the individual and the individual, initially, ran from them. However, the individual, subsequently, turned and assaulted one of the officers. The individual was arrested and placed in jail. The CSB contacted the magistrate and the jail regarding the need for the individual to be evaluated prior to release from the jail by bond or court. The individual was evaluated by the CSB in the jail and found to meet TDO criteria. The jail declined to petition for the TDO and reported they could manage the individual within the jail. The CSB provided the magistrate and the judge a copy of the preadmission screening report; however, the individual was bonded out of jail. When the CSB learned the individual was no longer in custody, an ECO was issued. The CSB attempted to make contact with the individual and the family. A family member responded to the attempts and reported they were taking the individual to another CSB to be evaluated. The family member lives outside of Virginia so the CSB contacted law enforcement in that locality to provide information on the suspected dangerousness of this individual and the concern for his welfare. Law enforcement attempted a wellness check at the home but no one answered the door and no signs of activity were found. It was determined the next day the family was in a hotel in another part of Virginia. The family contacted a psychiatrist who had treated the individual during a previous inpatient psychiatric hospitalization. The psychiatrist urged the family to take the individual to an emergency department for evaluation. The CSB where the individual was originally seen contacted the CSB in the area of the emergency department to provide them with background information and a copy of the initial preadmission screening report. The individual had medical needs that were being address and a TDO to a local facility was obtained.

   DBHDS reviewed the event and offered no recommendations.

7. The individual presented to a local CSB for an assessment and reported she had purchased pills and was having thoughts of suicide. The individual was not willing to be assessed for voluntary admission for treatment but did agree to meet with the emergency services clinician to learn more about other options for crisis supports and interventions. While the clinician was coordinating with the emergency services clinician, the individual left building. The CSB sought and obtained an ECO. The individual did not respond to multiple phone calls from the CSB. The ECO expired unexecuted. Law enforcement was not able to locate the individual.

   The CSB developed and implemented new protocols for their interview rooms. The staff were educated on the new protocols to prevent individuals from leaving the site without staff knowledge.

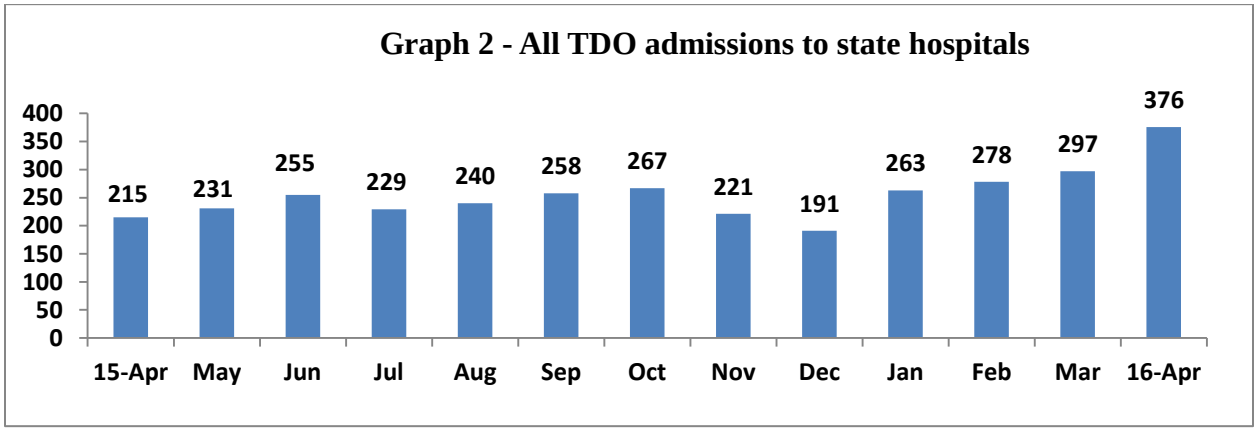
   DBHDS reviewed the event and offered no additional recommendations.

The DBHDS Quality Review Team reviewed each of these reports on the events as they were submitted. The team works with each CSB to ensure events are reviewed by the CSB and with community partners involved in the events to strengthen the safety of individuals determined to be in need of involuntary hospitalization. DBHDS provides technical assistance to CSBs on developing community partnerships with emergency departments and law enforcement. This includes analyzing each event in a community and adjusting practices to support individuals interacting with the involuntary commitment process in Virginia.

Graph 2: All TDO Admissions to State Hospitals

Under statutory provisions, when an individual is in emergency custody and needs temporary detention and no other temporary detention facility can be found by the end of the 8-hour period of emergency custody, the state hospital shall admit the individual for temporary detention. CSBs are organized into seven partnership planning regions to manage their utilization of state and local inpatient psychiatric beds. Each region has developed Admission Protocols outlining the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.

Graph 2 includes all TDO admissions to state hospitals including those where the facility was considered as a "last resort" and admissions where the hospital is facility of choice for the individuals. **Of the 2,229 TDOs executed in April, 376 (16%) resulted in admission to a state hospital.** [1]



Graph 3. State hospital TDOs without ECOs

As the hospital of "last resort" DBHDS facilities admit individuals who need temporary detention for whom no alternative placement can be found, whether or not the individual is under

[1] Source: DBHDS AVATAR admitting CSB data- Last Resort Data is collected by the CSBs and reported by the regions

an ECO. CSBs report every "last resort" admission where no ECO preceded the admission. In April, there were 46 admissions without ECOs to a state hospital, which is an increase of 53% from March.

Individuals are admitted to a state hospital as a "last resort" with or without a preceding ECO due to a lack of capacity of the alternate facilities contacted by the CSB, specialized care due to the individual's age (children and adolescents or adults aged 65 and older), diagnoses of intellectual or developmental disability, medical needs beyond the capability of the alternate facilities contacted, traumatic brain injuries, and behavioral needs exceeding the capabilities of the alternate hospitals contacted.